RULES AND REGULATIONS GOVERNING MANAGED CARE ORGANIZATIONS (MCO)

PART FOUR

SECTION 69.4 QUALITY ASSURANCE AND OPERATIONS

69.401 Health Care Professional Credentialing

A. General Responsibilities, an MCO shall:

1. Establish written policies and procedures for credentialing verification of all health care professionals with whom the MCO contracts and apply these standards consistently;

2. Verify the credentials of a health care professional before entering into a contract with that health care professional. The medical director of the MCO or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification;

3. Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification;

4. Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures;

5. Retain all records and documents relating to a health care professionals credentialing verification process for not less than four (4) years; and,

6. Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

B. Nothing in these regulations shall be construed to require an MCO to select a provider as a participating provider solely because the provider meets the MCO's credentialing verification standards, or to prevent the MCO from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

C. Selection standards for participating providers shall be developed for primary care professionals and each health care professional discipline. The standards shall be used in determining the selection of health care professionals by the MCO, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of 69.401 A. and 69.401 D. Selection criteria shall not be established in a manner:

1. That would allow an MCO to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or,

2. That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

D. Qualifications of primary care providers

1. Physicians qualified to function as primary care providers include: licensed physicians who have successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, general practice, pediatrics, obstetrics-gynecology or who are diplomats of one of the above certifying boards approved by the American Board of Medical Specialties or one of the certifying boards of the American Osteopathic Association.

E. Verification Responsibilities, an MCO shall:

1. Obtain primary verification of at least the following information about the applicant:

a) current license, certification, or registration to render health care in Delaware and history of same;

b) current level of professional liability coverage, if applicable;

c) status of hospital privileges, if applicable;

d) specialty board certification status, if applicable; and,

e) current Drug Enforcement Agency (DEA) registration certificate, if applicable.

2. Obtain, subject to either primary or secondary verification:

a) the health care professional's record from the National Practitioner Data Bank; and,

b) the health care professional's malpractice history.

1. Not less than every three (3) years obtain primary verification of a participating health care professional's:

a) current license or certification to render health care in Delaware;

b) current level of professional liability coverage, if applicable;

c) status of hospital privileges, if applicable;

d) current DEA registration certificate, if applicable; and,

e) specialty board certification status, if applicable.

4. Require all participating providers to notify the MCO of changes in the status of any of the items listed in this section at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this section.

F. Health Care Professionals Right to Review Credentialing Verification Information

1. An MCO shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application as set forth below.

a) Each health care professional who is subject to the credentialing verification process shall have the right to review all information, including the source of that information, obtained by the MCO to satisfy the requirements of this section during the MCO's credentialing process.

b) An MCO shall notify a health care professional of any information obtained during the MCO's credentialing verification process that does not meet the MCO's credentialing verification standards or that varies substantially from the information provided to the MCO by the health care professional, except that the MCO shall not be required to

reveal the source of information if the information is not obtained to meet this requirement, or if disclosure is prohibited by law.

c) a health care professional shall have the right to correct any erroneous information. The MCO shall have a formal process by which a health care professional may submit supplemental or corrected information to the MCO's credentialing verification committee and request a reconsideration of the health professional's credentialing verification application if the health care professional feels that the MCO's credentialing verification committee has received information that is incorrect or misleading. Supplemental information shall be subject to confirmation by the MCO.

69.402 Provider Network Adequacy

A. Primary, Specialty and Ancillary Providers

1. The MCO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care resources to serve the enrolled population at all times. The MCO shall develop and submit annually to the Department policies and procedures for measuring and assessing the adequacy of the network. At a minimum, the network of providers shall include:

a) A sufficient number of licensed primary care providers under contract with the MCO to provide basic health care services. All enrollees must have immediate telephone access seven (7) days a week, twenty-four (24) hours a day, to their primary care provider or his/her authorized on-call back-up provider;

b) A sufficient number of licensed medical specialists available to MCO enrollees to provide medically necessary specialty care. The MCO must have a policy assuring reasonable access to frequently used specialists within each service area; and,

c) A sufficient number of other health professional staff including but not limited to licensed nurses and other professionals available to MCO enrollees to provide basic health care services. If a plan has an insufficient number of providers within reasonable geographic distances and appointment times to meet the medical needs of the enrollee, the MCO shall cover nonparticipating providers, and shall prohibit balance billing.

2. The MCO shall allow referral to a non-network provider, upon the request of a network provider, when medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time. The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing.

B. Facility and Ancillary Health Care Services

1. The MCO shall maintain contracts or other arrangements acceptable to the Department with institutional providers which have the capability to meet the medical needs of enrollees and are geographically accessible. The network of providers shall include:

a) At least one licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in any service area no greater than thirty (30) miles or forty (40) minutes driving time from ninety percent (90%) of enrollees within the service area.

b) Surgical facilities including hospitals licensed ambulatory surgical facilities, and/or physicians surgical practices. Such services shall be available in each service area no greater than thirty (30) miles or forty (40) minutes driving time from ninety percent (90%) of enrollees within the service area.

c) The MCO shall have a policy assuring access to the following specialized services, as determined to be medically necessary:

(1) at least one hospital providing regional perinatal services;

(2) a hospital offering pediatric intensive care services;

(3) a hospital offering neonatal intensive care services;

(1) therapeutic radiation provider;

(2) magnetic resonance imaging center;

(6) diagnostic radiology provider, including X-ray, ultrasound, and CAT scan;

(7) emergency mental health service;

(8) diagnostic cardiac catheterization services in a hospital;

(1) specialty pediatric outpatient centers for conditions including sickle cell, hemophilia, cleft lip and palate, and congenital anomalies;
(2) clinical Laboratory certified under CLIA; and, certified renal dialysis provider.

Such services shall be reasonably accessible. Evidence indicating such services shall include contracts or other agreements acceptable to the Department.

2. If offered by the plan, the MCO shall have a policy assuring access to the following specialized services, as determined to be medically necessary:

a) a licensed long term care facility with skilled nursing beds;

b) residential substance abuse treatment center;

c) inpatient psychiatric services for adults and children;

d) short term care facility for involuntary psychiatric admissions;

e) outpatient therapy providers for mental health and substance abuse conditions;

f) home health agency licensed by the Department;

g) hospice program licensed by the Department; and, pharmacy services.

Such services shall be reasonably accessible. Evidence indicating such services shall include contracts or other agreements acceptable to the Department.

3. The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing, if the appropriate level of service is not available within the geographical service area. These services will not be limited to the State of Delaware. These services could include but are not limited to tertiary services, burn units and transplant services.

C. Emergency and Urgent Care Services

1. The MCO shall establish written policies and procedures governing the provision of emergency and urgent care which shall

be distributed to each enrollee at the time of initial enrollment and after any revisions are made. These policies shall be easily understood by a layperson.

2. When emergency care services are performed by non-network providers, the MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing. In those cases where the MCO and the provider cannot agree upon the appropriate charge, the provider may appeal to the Commissioner for arbitration.

3. Enrollees shall have access to emergency care (69.117) twenty-four (24) hours per day, seven (7) days per week. The MCO shall cover emergency care necessary to screen and stabilize an enrollee and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition (69.118) existed.

4. Emergency and urgent care services shall include but are not limited to:

   a) medical and psychiatric care, which shall be available twenty-four (24) hours a day, seven (7) days a week;

   b) trauma services at any designated Level I or II trauma center as medically necessary. Such coverage shall continue at least until the enrollee is medically stable, no longer requires critical care, and can be safely transferred to another facility, in the judgment of the treating physician. If the MCO requests transfer to a hospital participating in the MCO network, the patient must be stabilized and the transfer effected in accordance with federal regulations at 42 CFR 489.20 and 42 CFR 489.24;

   c) out of area health care for urgent or emergency conditions where the enrollee cannot reasonably access in-network services;

   d) hospital services for emergency care; and,

   e) upon arrival in a hospital, a medical screening examination, as required under federal law, as necessary to determine whether an emergency medical condition exists.

5. When an enrollee has received emergency care from a non-network provider and is stabilized, the enrollee or the provider

must request approval from the MCO for continued post-stabilization care by a non-network provider. The MCO is required to approve or disapprove coverage of post-stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the enrollee, but in no case to exceed one hour from the time of the request.

D. All enrollees shall be provided with an up-to-date and comprehensive list of the provider network upon enrollment and upon request. Updates due to provider changes must be provided at least quarterly.

69.403 Utilization Management

A. Utilization Management Functions

1. The MCO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of a designated physician and shall be based on a written plan that is reviewed at least annually. The plan shall identify at least:

a) scope of utilization management activities;

b) procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

c) mechanisms to detect under utilization;

d) clinical review criteria and protocols used in decision-making;

e) mechanisms to ensure consistent application of review criteria and uniform decisions;

f) system for providers and enrollees to appeal utilization management determinations in accordance with the procedures set forth; and,

g) a mechanism to evaluate enrollee and provider satisfaction with the complaint and appeals systems set forth. Such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program set forth.

2. Utilization management determinations shall be based on written clinical criteria and protocols reviewed and approved by practicing physicians and other licensed health care providers within the network. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and enrollees. All materials including internal or proprietary materials for utilization management shall be available to the Department upon request.

3. Compensation to persons providing utilization review services for an MCO shall not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

B. Utilization Management Staff Availability

1. At a minimum, appropriately qualified staff shall be immediately available by telephone, during routine provider work hours, to render utilization management determinations for providers.

2. The MCO shall provide enrollees with a toll free telephone number by which to contact customer service staff on at least a five (5) day, forty (40) hours a week basis.

3. The MCO shall supply providers with a toll free telephone number by which to contact utilization management staff on at least a five (5) day, forty (40) hours a week basis.

4. The MCO must have policies and procedures addressing response to inquiries concerning emergency or urgent care when a PCP or her/his authorized on call back up provider is unavailable.

C. Utilization Management Determinations

1. All determinations to authorize services shall be rendered by appropriately qualified staff.

2. All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MCO's Delaware enrollees. Such determinations shall be made in accordance with clinical and medical criteria and standards and

shall take into account the individualized needs of the enrollee for whom the service, admission, procedure is requested.

3. All determinations shall be made on a timely basis as required by the exigencies of the situation.

4. An MCO may not retroactively deny reimbursement for a covered service provided to an enrollee by a provider who relied upon the written or verbal authorization of the MCO or its agents prior to providing the service to the enrollee, except in cases where the MCO can show that there was material misrepresentation, fraud or the patient was found not to have coverage.

5. An enrollee must receive upon request a written notice of all determinations to deny coverage or authorization for services required and the basis for the denial.

69.404 Appeal Procedure

A. Scope of Appeal

The following appeal procedure shall be utilized when the subject of the appeal is based upon medical necessity (69.133) or disputable need (69.116). For all other appeals, the carrier shall develop and implement written policies and procedures that require a review process and a written response to the appellant.

B. Appeal Procedure

1. Information Disclosure

A carrier shall provide enrollees with a written explanation of the appeal process upon enrollment, annually, upon request and each time the appeal process is substantially changed. A carrier shall also provide participating providers with a written explanation of the appeal process, upon initial participation with the carrier network, upon request and each time the appeal process is substantially changed.

2. Stages of Appeal Process

a) A carrier shall establish an appeal process for appellants for review of coverage determinations based on medical necessity (69.133) or disputable need (69.116). The appeal process shall consist of the following stages: an internal review by the carrier ("Stage 1 Appeal"), a second subsequent internal review by the

carrier ("Stage 2 Appeal") and an external review ("Stage 3 Appeal").

b) Each stage of the appeal process shall provide for expedited review that shall not exceed seventy-two (72) hours.

(1) **I**n the event that the subject of the appeal concerns an imminent, emergent, or serious threat to the appellant, each stage (1, 2, and 3) of the appeal process may take seventy-two (72) hours each.

(2) In the event that the subject of the appeal concerns an emergency medical condition (69.118), both stages of internal review (stage 1 and 2) must be concluded within a total of seventy-two (72) hours. Stage 3 must be completed within an additional seventy-two (72) hours.

3. Petition for External Review form

All carriers shall complete a DHSS approved form and forward it to the Department to initiate the Independent Health Care Appeals Program.

4. Waiver of Internal Review Process

In the event that the carrier fails to comply with any of the deadlines for completion of the Stage 1 or 2 appeals, or in the event that the carrier for any reason waives its rights to an internal review of any appeal, then the appellant shall be relieved of her/his obligation to complete the carrier internal review process, and at the appellant's option, may proceed directly to the Stage 3 appeal process.

5. Appellant Rights.

a) A carrier shall not disenroll, terminate or in any way penalize an enrollee who exercises the right to appeal solely on the basis of filing the appeal.

b) Carrier Assistance

(1) Upon the initiation of an appeal, a carrier shall notify an appellant of the right to have a staff member appointed to assist her/him with understanding the appeal process. Such assistance shall be available during the appeal process.

(2) An appellant may request such assistance at any stage of the appeal process.

(3) Upon such request, a carrier shall appoint a member of its staff who has had no prior direct involvement in the case to assist the appellant.

c) After an adverse determination, an appellant shall have the right to discuss a coverage determination with the medical director, or physician designee, of the carrier who made the coverage determination.

6. Carrier Records

A carrier shall maintain written or electronic records to document all appeals received. For each appeal a carrier shall maintain, at a minimum, the following information:

a) a general description of the reason for the appeal;

b) date received;

c) date of each review;

d) resolution at each stage of appeal;

e) date of resolution at each stage; and,

f) name and plan identification number of the appellant for whom the appeal was filed.

7. Reporting

A carrier shall submit the following information to the Department within thirty (30) days after the close of each calendar quarter:

a) the total number appeals (69.102) filed.

b) the number of Stage 1 appeals. This shall include only those appeals based upon medical necessity (69.133) and/or disputable need (69.116).

c) the number of Stage 1 appeals upheld.

d) the number of Stage 1 appeals overturned.

e) the number of Stage 2 appeals. This shall include only those appeals based upon medical necessity (69.133) and/or disputable need (69.116).

f) the number of Stage 2 appeals upheld.

g) the number of Stage 2 appeals overturned.

h) the number of petitions made to the Independent Health Care Appeals Program.

C. Stage 1 Appeal Procedure

1. Procedure

A carrier shall establish and maintain an internal appeal procedure in which an appellant, who is dissatisfied with a coverage determination by the carrier, that is based on medical necessity or disputable need, shall have the opportunity to appeal the determination. This appeal is made to the carrier who will then assign the medical director and/or a physician designee, who has had no prior direct involvement with the appellant's case, to conduct the review.

2. Timeframes

A Stage 1 appeal shall be concluded as soon as possible in accordance with the medical exigencies of the case but no more than five (5) business days after receipt of the appeal. In no event shall appeals that involve an imminent, emergent, or serious threat to the health of the appellant exceed seventy-two (72) hours.

3. Notice of Determination

A carrier shall provide notice of the Stage 1 appeal determination to the appellant within five business days of receipt of the appeal. If such notice is provided verbally to the appellant, the carrier shall provide written notice of the determination to the appellant within five (5) business days of the verbal notice. In the event that the adverse determination is upheld, the written notice shall include the reason for the determination, an explanation of the appellant's right to proceed to a Stage 2 appeal and a review of the entire appeals process. This information shall include specific contact information (address and phone number) that is appropriate for each appeal stage.

D. Stage 2 Appeal Procedure

1. A carrier shall establish and maintain an internal appeal procedure in which an appellant who is dissatisfied with a Stage 1 appeal determination by a carrier shall have the opportunity to appeal the determination to the carrier. A panel, selected by the carrier, shall consist of at least two (2) physicians and/or other health care professionals having no direct involvement with the appellant's case prior to this review, one of who should be in the same or similar specialty that typically manages the care under review. If the same or similar physician/health care professional is not a member of the panel, such physician/health care professional must consult on the health care service at issue and report such consultation in writing to the panel for consideration.

2. Written Notice of Meeting

   A carrier shall acknowledge receipt of all Stage 2 appeals in writing to the appellant. This acknowledgement shall include the place, date and time of the Stage 2 appeal meeting and shall give the appellant at least fifteen (15) calendar days notice of the appeal meeting. The appellant may request a change in the meeting schedule to facilitate attendance.

3. Appeal Meeting

   The carrier shall hold the Stage 2 appeal meeting during regular business hours at a location reasonably accessible to the appellant. If a face-to-face meeting is not practical for geographic reasons, the carrier shall offer the appellant the opportunity to communicate with the review panel, at the carrier's expense, by conference call, video-conferencing, or other appropriate technology. The carrier shall not unreasonably deny a request for postponement of the meeting made by an appellant. The appellant's right to a fair review shall not be conditional on the appellant's appearance at the Stage 2 appeal meeting.

4. Appellant Rights

   An appellant has the right to:

   a) attend the Stage 2 appeal;

   b) present his or her case to the review panel;

c) submit supporting material both before and at the appeal meeting;

d) ask questions of any representative of the carrier participating on the panel;

e) be accompanied and supported by a person of her/his choice in addition to her/his representative; and,

f) review all relevant information that is not confidential, proprietary or privileged.

4. Timeframes

5. A Stage 2 appeal shall be concluded as soon as possible in accordance with the medical exigencies of the case but no more than thirty (30) calendar days after receipt of the request for the Stage 2 appeal. In no event shall a Stage 2 appeal involving an imminent, emergent or serious threat to the health of the appellant exceed seventy-two (72) hours.

6. Extensions

The carrier may extend the Stage 2 appeal for up to an additional thirty (30) calendar days for reasonable cause by submitting a written explanation for the delay to the Department within the original thirty (30) calendar day review period. A carrier honoring an appellant's request for extension for necessity or convenience shall be deemed a reasonable cause. In no event may a carrier extend the review period for an expedited appeal.

7. Written Notice of Determination
A carrier shall provide written notice of the Stage 2 appeal determination to the appellant within five (5) business days of such determination. In the event of an adverse determination, such notice shall include:

a) the qualifications of the members of the Stage 2 appeal panel;

b) a statement of the panel's understanding of the nature of the appeal and all pertinent facts;

c) the rationale for the review panel's determination;

d) reference to evidence or documentation considered by the panel in making that determination;

e) instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and,

f) the appellant's right to proceed to a Stage 3 appeal.

E. Independent Health Care Appeals Program (External Appeal Process/Stage 3)

1. Upon receipt of an adverse determination at Stage 2, any appellant who is dissatisfied with the results, shall have the opportunity to pursue her/his appeal before an independent utilization review organization.

2. The appellant must file the request for appeal with the carrier within sixty (60) calendar days of receipt of the adverse determination from the internal review process.

3. Upon receipt of a request for external review, the carrier shall fax the Petition for External Review form as soon as possible but within no more than three (3) business days to the Department and shall send a hard copy of the request to the Department by mail.

4. The Department shall assign an approved IURO (69.127) to conduct the external review and shall notify the carrier.

6. The assigned IURO shall, within five (5) calendar days of assignment, notify the appellant in writing by certified or registered mail, that the appeal has been accepted for external review. The notice shall include a provision stating that the appellant may submit additional written information and supporting documentation that the IURO shall consider when conducting the external review. Appellant shall submit such written documentation to the IURO within seven (7) calendar days following the date of receipt of the notice.

a) Upon receipt of any information submitted by the appellant, the assigned IURO shall as soon as possible but within no greater than two (2) business days, forward the information to the carrier.

b) The IURO must accept additional documentation submitted by the carrier in response to additional written information and supporting documentation from the appellant.

6. Within seven (7) business days after the receipt of the notification required in 69.404.E.4, the carrier shall provide to the assigned IURO, the documents and any information considered in making the internal appeal determination.

    a) If the carrier fails to submit documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the internal appeal determination.

7. The external review may be terminated if the carrier decides to reverse its adverse determination and provide coverage or payment for the health care service that is the subject of the appeal.

    a) Immediately upon making the decision to reverse its adverse determination, the carrier shall notify the appellant, the assigned IURO, and the Department in writing of its decision.

    b) Te assigned IURO shall terminate the external review upon receipt of the written notice from the carrier.

8. Within forty-five (45) calendar days after the receipt of the request for external review, the assigned IURO shall provide written notice of its decision to uphold or reverse the adverse determination to:

    a) the appellant;

    b) the carrier; and,

    c) the Department.

9. The IURO shall include the following information in the notice sent pursuant to 69.404.E.8:

    a) the qualifications of the members of the review panel;

    b) a general description of the reason for the request for external review;

    c) the date the IURO received the assignment from the Department to conduct the external review;

    d) the date(s) the external review was conducted;

e) the date of its decision;

f) the principal reason(s) for its decision; and,

g) references to the evidence or documentation, including practice guidelines and clinical review criteria, considered in reaching its decision.

10. The decision of the IURO is binding upon the carrier.

F. Expedited External Utilization Appeal Process

1. An appellant may request an expedited external review with the carrier at the time the enrollee receives a final adverse determination if the enrollee suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

2. At the time the carrier receives a request for an expedited external review, the carrier shall immediately fax the Petition for External Review form to the Department and shall send a hard copy to the Department by mail.

3. If the Department determines that the review meets the criteria for expedited review, the Department shall assign an approved IURO to conduct the external review and shall notify the carrier.

4. At the time the carrier receives the notification of the assigned IURO, the carrier shall provide or transmit all necessary documents and information considered in making the final adverse determination to the assigned IURO electronically, by telephone, by facsimile or any other available expeditious method.

5. As expeditiously as the enrollee's medical condition permits or circumstances require, but in no event more than seventy-two (72) hours after the date of the receipt of the request for an expedited external review, the IURO shall:

a) make a decision to uphold or reverse the final adverse determination; and

b) immediately notify the appellant, the carrier, and the Department of the decision.

6. Within two (2) calendar days of the immediate notification, the assigned IURO shall provide written confirmation of the decision to the appellant, the carrier, and the Department

7. The decision of the IURO is binding upon the carrier.

G. Petition to DHSS

1. If a carrier receives an appellant's request for access to the IHCAP whose subject is a benefit that is a written exclusion from the enrollee's benefit package, the carrier may make a written request to have the appeal reviewed for appropriate inclusion in the IHCAP by the Department. The request must be made in writing at the time the Petition for External Review Form is faxed to the Department and include any necessary supporting documentation.

2. The Department shall review the petition and may, in its discretion:

a) dismiss the appeal and notify the appellant in writing that the appeal is inappropriate for the IHCAP; or,

b) appoint an IURO to conduct a preliminary review; or,

c) appoint an IURO to conduct a full external review.

H. Preliminary External Review

1. If a carrier receives an appellant's request for access to the IHCAP for an appeal that it believes is not appropriate for inclusion in the IHCAP, the carrier may file a motion to dismiss. The motion must be made in writing at the time the Petition for External Review Form is faxed to the Department and include any necessary supporting documentation.

2. Upon the written request of an carrier, the Department shall review the petition and:

a) appoint an IURO to review the details of the motion to determine if the appeal is appropriate for inclusion in the IHCAP.

(1) appeals that are inappropriate for inclusion are dismissed.

(2) appeals that are appropriate for inclusion are subject to a full external review.

b) appoint an IURO to conduct a full external review.

I. All costs for external IURO review shall be borne by the carrier. The carrier shall reimburse the Department for the cost of the review within ninety (90) calendar days of the receipt of the decision by the IURO.

J. The Department shall approve IUROs eligible to be assigned to conduct external reviews.

1. Any IURO wishing to be approved to conduct external reviews shall submit an application form (as developed by the Department) and include with the form, all documentation and information necessary for the Department to determine if the IURO satisfies minimum qualifications.

2. The Department shall maintain a current list of approved IUROs.

69.405 Quality Assessment and Improvement

A. Continuous Quality Improvement

1. Under the direction of the Medical Director or her/his designated physician, the MCO shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to enrollees. This program shall be based on a written plan which is reviewed at least semi-annually and revised as necessary. The plan shall describe at least:

a) the scope and purpose of the program;

b) the organizational structure of quality improvement activities;

c) duties and responsibilities of the medical director and/or designated physician responsible for continuous quality improvement activities;

d) contractual arrangements, where appropriate, for delegation of quality improvement activities;

e) confidentiality policies and procedures;

f) specification of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized;

g) a system of ongoing evaluation activities, including individual case reviews as well as pattern analysis;

h) a system of focused evaluation activities, particularly for frequently performed and/or highly specialized procedures;

i) a system of monitoring enrollee satisfaction and network provider's response and feedback on MCO operations;

j) a system for verification of provider's credentials, recertification, performance reviews and obtaining information about any disciplinary action against the provider available from the Delaware Board of Medical Practice or any other state licensing board applicable to the provider;

a) the procedures for conducting peer review activities which shall include providers within the same discipline and area of clinical practice; and,

b) a system for evaluation of the effectiveness of the continuous quality improvement program.

2. There shall be a multidisciplinary continuous quality improvement committee responsible for the implementation and operations of the program. The structure of the committee shall include representation from the medical, nursing and administrative staff, with substantial involvement of the medical director of the MCO.

3. The MCO shall assure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system.

4. The MCO shall provide enrollees the opportunity to comment on the quality improvement process.

5. The program shall monitor the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators of quality care for evaluating the health care services provided by all participating providers shall be identified and established and shall include at least:

a) a mechanism for monitoring enrollee appointment and triage procedures including wait times to get an appointment and wait times in the office;

b) a mechanism for monitoring enrollee continuity of care and discharge planning for both inpatient and outpatient services;

c) a mechanism for monitoring the appropriateness of specific diagnostic and therapeutic procedures as selected by the continuous quality improvement program;

d) a mechanism for evaluating all providers of care that is supplemental to each provider's quality improvement system;

e) a mechanism for monitoring network adequacy and accessibility to assure the network services the needs of their diverse enrolled population; and,

f) a system to monitor provider and enrollee access to utilization management services including at least waiting times to respond to telephone requests for service authorization, enrollee urgent care inquiries, and other services required.

6. The MCO shall develop a performance and outcome measurement system for monitoring and evaluating the quality of care provided to MCO enrollees. The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. Data for these performance measures shall include but not be limited to the following:

a) indicator data collected by MCOs from chart reviews and administrative databases;

b) enrollee satisfaction surveys;

c) provider surveys;

d) annual reports submitted by MCOs to the Department; and,

e) computerized health care encounter data.

7. The MCO shall follow-up on findings from the program to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes and implementation of educational activities for enrollees and providers.

8. Continuous quality improvement activities shall be coordinated with other performance monitoring activities including utilization management and monitoring of enrollee and provider complaints.

9. The MCO shall maintain documentation of the quality improvement program in a confidential manner. This documentation shall be available to the Department and shall include:

a) minutes of quality improvement committee meetings; and,

b) records of evaluation activities, performance measures, quality indicators and corrective plans and their results or outcomes.

B. External Quality Audit

1. Each MCO shall submit, as a part of its annual report due June 1, evidence of its most recent external quality audit that has been conducted or of acceptable accreditation status. External quality audits must be completed no less frequently than once every three (3) years. Such audit shall be performed by a nationally known accreditation organization or an independent quality review organization acceptable to the Department.

a) MCOs must submit the following information to the Department in order to receive approval for the nationally known accreditation organization or independent quality review organization that will conduct the triennial reviews or perform accreditation for the MCO:

(1) evidence that the nationally known accreditation organization or independent quality review organization has experience performing external quality audits or accreditation of MCOs; and,

(2) the current standards for independent quality reviews or accreditations of MCOs as established and maintained by the accrediting entity.

2. The report must describe in detail the MCO's conformance to performance standards and the rules within these regulations. The report shall also describe in detail any corrective actions proposed and/or undertaken by the MCO.

3. In lieu of the external quality audit, the Department may accept evidence that each MCO has received and has maintained the appropriate accreditation from a nationally known accreditation organization or independent quality review organization.

C. Reporting and Disclosure Requirements

1. The Board of Directors of the MCO shall be kept apprised of continuous quality improvement activities and be provided at least annually with regular written reports from the program delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality.

2. An MCO shall document and communicate information about its quality assessment program and its quality improvement program, and shall:

   a) include a summary of its quality assessment and quality improvement programs in marketing materials;

   b) include a description of its quality assessment and quality improvement programs and a statement of enrollee rights and responsibilities with respect to those programs in the materials or handbook provided to enrollees; and,

   c) make available annually to providers and enrollees findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

3. MCOs shall submit such performance and outcome data as the Department may request.